Laurel Hill Inn
Eating Disorder Treatment Centers

80943

July 11, 2011

Martha Coakley
Attorney General
One Ashburton Place 20th FL
Boston, MA 02108

RE: Antitrust Complaint #2 /Part 1

Dear Attorney General Coakley:

This letter contains Part 1 of the second antitrust complaint that I have filed with the MA AGO. I submitted my original complaint on February 16, 2009. Part 2 of this complaint will follow in the next few days. Part 2 will demonstrate the impact of anti-competitive behaviors on a sample of healthcare consumers and small providers.

The MA AGO did not respond formally to my first complaint. However, in an amazing coincidence of timing, less than thirty days after I filed, a BCBSMA Vice President contacted my company, Laurel Hill Inn (LHI) and told us that BCBSMA would now like LHI to join its network of behavioral health providers. It took about seven months to bring us in. Several months after that, over the course of about eight weeks Cigna, Aetna and Tufts Health Plan also called us spontaneously and invited us to join their networks as well. I had spent the previous eight years seeking to persuade each of these Plans to allow us to join their networks, all to no avail. We continue to be excluded from the behavioral health networks of United HealthCare including all of its affiliates and subdivisions such as United Behavioral Health.

EXECUTIVE SUMMARY

We're all familiar by now with the phrase, "Too big to fail". If Accountable Care Organizations and Global Payments are permitted to run their course we'll all become familiar with a new phrase, "Too wealthy and too politically influential to be criminally prosecuted."

Although my company has incurred very substantial losses as a result of what I consider to be anticompetitive business practices, I do not seek to recover any of those losses through this complaint. I do seek to have all anti-competitive business practices in the intensive treatment market for eating disorders to cease and to have what should be my right to compete without restriction in this market protected.

OFFICE 781.396.1116 FAX 781.391.8820 lhi@laurelhillinn.com
P.O. BOX 368 MEDFORD, MA 02155-0004 www.laurelhillinn.com

If there was genuine competition among providers at the procedure level in Massachusetts healthcare and if consumers were permitted to direct their benefit dollars to the provider of their choice while purchasing the procedure or treatment that they needed and wanted, Massachusetts healthcare would consistently deliver high value products and services and there would be no need for the discussions we are currently having.

Healthcare is the only industry in which products, services and other healthcare solutions are conceived, designed and delivered by massive bureaucracies, private and public, that have the political and economic power to impose those "solutions" on society. It is a top-down product/service creation and delivery structure. In every other industry and marketplace we have available to us, and benefit most from, there exists a bottoms-up product/service creation and delivery structure. In this conventional bottoms-up production/service creation structure consumers individually and collectively express their needs and preferences with their purchasing power. Sellers then determine what type of product/service creation and delivery structures allow them to best respond to consumer demand effectively and cost-effectively.

DETAILED DISCUSSION

THE PROBLEM

Pricing, valuation and selection of healthcare services have been contrasted with the way that we procure products and services in every other marketplace outside of healthcare. It's fair to say that there is broad consensus that we successfully carry out value based or value informed purchasing decisions everywhere in our lives except in the purchase of healthcare. We express our preferences with our money and we get the price-quality combination or value that we desire. By and large, we do not feel cheated or short changed in the value we obtain in our non-healthcare transactions, especially if we perform our "due diligence" prior to executing those transactions.

The further you allow healthcare valuation to be distanced from the actual procedure being delivered, the greater is the opportunity to imbed larger and larger amounts of fat, fraud, waste and corruption in the ultimate price.

All of the discussions thus far regarding purchasing healthcare include the primary limitation of valuing a "Promise-to-Pay", rather than valuing actual units of healthcare that are both measurable and easily comparable. "Promises", usually articulated in the Subscriber Certificate or Certificate of Coverage (75p to 150p- usually located in the Member Benefits section of the Plan website) have a long history of being difficult to understand as well as deceptive and misleading for the average consumer. Since we do not typically know which one or which number of the 150 categories of illness, disease, injury or impairment we are likely to experience when we buy the Promise-to-Pay, we rarely ever scrutinize our health plan contract thoroughly. Forcing consumers to buy a "Promise" instead of the unit of care they actually want and need leads to a horribly imprecise and wasteful pricing methodology.

The numbers included in the MA AGO's Examination of Health Care Cost Trends and Cost Drivers demonstrate unequivocally the utter failure of a healthcare pricing system that is designed operationally around, and limited to purchasing a Promise-to-Pay instead of pricing and purchasing the actual unit of healthcare that we eventually need. Such a dysfunctional procurement process serves only the interests of the major financial stakeholders in healthcare who collectively control the entire delivery and reimbursement apparatus of healthcare. It is not in any consumer's best interests, nor is it in society's best interests to procure our healthcare in this fashion.

All of the healthcare analyzing and solution seeking that is now occurring continues to put the insurance plan at the center of the procurement model because we operate under the highly flawed assumption that "the Plan" performs a value creation function through its "negotiations" with providers. It would be outrageous if the Plan simply added NO Value to the procurement process. Unfortunately, the problem is quite a bit worse than simply adding no value. In fact the Plan conspires with large healthcare delivery systems to conceal the essential information that would inform buyers about the true value of the basic components of healthcare. This process operates to suck value out of the healthcare system, value that is then not passed through to consumers.

Popular proposals put forward during the hearings included Limited Networks and Tiered Networks. Limited Network is a failed concept for the same reasons that Network is a failed concept. It simply has a new, more aggressive sounding spin on the name. Tiered Networks are a very small step in the right direction but it is only a symbolic step. Creating co-pays that vary according to the relative price of all procedures that are offered by the hospital might be acceptable if I was looking to buy a hospital. But I'm looking to buy a procedure, not a hospital.

Health plans process claims and this function has a certain value for which Plans should be compensated. However, Health Plans do not create value or add value to the procurement process. They do not negotiate value on behalf of consumers. Unfortunately, the Plans add obfuscation, opaqueness and confusion, all of which have been essential in allowing the largest providers and their Plan partners to take value away from consumers as these consumers pursued treatments and services that would meet their healthcare needs.

TOWARD A SOLUTION

Trying to develop a new design of the procurement process based on the requirement that Plans must be included and compensated as if they were creators of value impedes the goal of achieving a value driven healthcare system.

It's necessary that insurance still play a role in the purchasing transaction; however, it should be a far more limited role. The role of the prospective healthcare consumer needs to be radically elevated in the procurement transaction to one in which the consumer directs the transaction rather than being passively directed to the healthcare silo within which she may be able to choose among a small number of specialists. The terms and conditions, as well as all limitations under which this consumer must now seek care were

prescribed in her health insurance contract long before she ever realized she would need this particular unit of healthcare. All of these limitations and unnecessary contractual complexities help to support an army of private sector bureaucrats that continues to have the power to restrict insurance choices to only those which benefit the insurer-provider partnership and which abuse and exploit the consumer.

In her new role as purchaser, the Member will direct her benefit dollars to the provider of her choice AFTER she has determined the entire medical cost of the required procedure. She will be responsible for 30%, 20%, 10% or some other portion of the total costs of this procedure depending on which plan she has selected and from which provider she chooses to receive her care. Providers can set their charge at whatever level they wish. If the provider sets its price too high to be covered by the Plan contribution and the Member's contribution, then the consumer will choose to obtain her care elsewhere. This is how a competitive marketplace works.

In a healthcare system guided by value informed decisions by consumers, insurers would sell health plans but the Member would be free to direct her benefit dollars to the provider of her choice. Since the Network has supposedly been the instrument by which Plans create their "high value" packages and since it has been demonstrated conclusively that Plans have operated only to diminish healthcare value, networks and any other instrument that restricts access to healthcare providers would be outlawed.

Plans would include a simple basic insurance function with a single reimbursement rate or perhaps, a few reimbursement rates. The higher the reimbursement rate, the higher the monthly premium. Any aspect of the plan that serves to complicate or confuse a person of average intelligence and thereby causes that person to not fully understand the benefits available to her under the Plan, would be considered a deceptive marketing practice and would therefore be unlawful. Since the primary purpose of deductibles, co-pays and co-insurance is to confuse the policy holder as to the true value of her plan, such plan attributes would also be unlawful.

ALL-PAYER CLAIMS DATABASE

Let me pick up on a comment that I heard at one of the presentations offered during the APCD discussion groups.

While I cannot recall his specific words David Wessman, Assistant Commissioner at the Division, commented that disclosing absolute dollar cost in the APCD as a means of empowering consumers to make value-based healthcare choices may NOT have the desired effect or outcome in all cases. He gave as an example the world class Burn Center that is owned and operated by Partners HealthCare. Mr. Wessman's comment seemed to suggest that in order to develop and maintain such highly specialized healthcare facilities Partners legitimately needs to earn a premium, and perhaps a substantial premium, on the thousands of other procedures and treatments that it offers

My Comment on Actual Price Disclosure

Mr. Wessman may have been picking up on a presentation by Peter Slavin, MD, President of Massachusetts General Hospital which he delivered, I believe, at an earlier open forum (Bundled Payments?) sponsored by the Division. Dr. Slavin made the point in his presentation that Partners/MGH needs to make more money than other hospitals on many of its procedures and treatments so that it can do many of the things for which it may not be fully or even partially reimbursed. Dr. Slavin gave as examples, a world class burn center, a level 1 trauma center, mental health services and training the next generation of physicians. Let me add to those mentioned the additional accomplishment of having performed the first full face transplant done in the United States at Brigham & Women's Hospital. As of now I believe that a total of four persons have received the full face transplant at Brigham & Women's.

If a politician says that his or her constituents are complaining about their skyrocketing insurance premiums, well, "Come on down Senator; you need to have a personal tour of the Lunder Building, and see first hand how MGH and Partners HealthCare are leading the way to the healthcare of the third millennium. And while you're here, you may as well check out the Level One Trauma Center and the World Class Burn Center."

This exercise leads inevitably to a flawed conclusion. While all of the services to which Dr. Slavin refers are laudable, they provide the basis for a very flawed defense of enormously inflated treatment prices and insurance premiums. Partners, like other large healthcare delivery systems and hospitals is able, through its massive political influence, to charge whatever prices it chooses for any procedure and the supporting arguments for those hefty prices are all of the wonderful services mentioned by Dr. Slavin.

The Lunder Building, the Yawkey Center, the Burn Center and the Trauma Center are all very tangible assets, as is the capability to do full face transplants. They are compelling both in appearance and in what they are able to accomplish through leading edge medical technology. However, these assets and capabilities enjoy an unfair advantage in that many of the people who paid for these extraordinary achievements through unnecessarily inflated prices and premiums, can no longer afford to pay the premiums that would give them continued access to the healthcare of the third millennium. If they have a job, and if they have insurance, it is insurance with greatly reduced benefits and reduced access from what they previously enjoyed. The clothes these folks wear now, the food they eat now, the toys they do not buy for their children now, their missed rent or mortgage payments, are substantially invisible. Their losses, including for many, job losses, cannot be fairly compared to the very tangible and very impressive achievements of Big Health Care. These folks do not have paid-lobbyists or executives that can spend time on Beacon Hill explaining with a collective voice that their lives are very different now and much less enjoyable.

If we advocate and subscribe to the concept of democracy, then we are compelled to support and protect the concepts of free enterprise, fair competition and the freedom to choose. Does the cost of the research as well as the preparation and training of large

numbers of medical specialists, including the operating room with all of its supporting equipment to do face transplants for four people justify taking away access to basic healthcare (Primary Care Physicians) for hundreds of thousands of people or perhaps millions? Competition and choice would have enabled hundreds of thousands of consumers to direct their purchasing dollars toward PCP's when they needed it. Had they been able to do so, we would have no shortage of PCP's today. Do all of the leading edge medical accomplishments justify the economic devastation that has been brought down upon individuals, families, small and medium size businesses, municipalities and state government? MA healthcare was a significant contributor to this devastation.

If consumers are permitted to control their healthcare procurement transactions directly, at the procedure level, it will cause healthcare to be delivered far more cost effectively. And the major financial stakeholders in healthcare know this very well. If there are compelling unmet needs for resources like burn centers and trauma centers, then society as well as Partners HealthCare will find a way to make those solutions happen.

So the challenge for the Division is a political one rather than one of application. The challenge is not about deciding which data types to use and which reports to run. The question is, will the Division ultimately require the APCD to be used to serve the interests of healthcare consumers? Or, will it be used to serve the interests of Big Health Care?

HEALTH CARE HEARINGS

For this discussion, my remarks are limited to consumers who have private commercial insurance and do not address the subsidized insurance market.

Opening Remarks by Julie Pinkham, Executive Director, Massachusetts Nurses Association

> "..I will provide you with the bedside nurses' view of what deregulation and unbridled competition have done to the health care system in Massachusetts."
>
> "The premise of deregulation, including the removal of the Determination of Need process, was driven by the belief that competition would spur efficiencies, cost reduction and enhanced quality. In reality, none of this occurred. Rather, the need to keep up with the competition has spurred institutions to mirror services already available at the same time that market leverage has allowed pricing to increase."

Ms. Pinkham's remarks mirror those of many people in Massachusetts and they are certainly consistent with those of the highly compensated healthcare consultants and opinion makers who constantly make references in various ways to the "white hot competition in the downtown market." These opinion makers, which would include all large financial stakeholders in Massachusetts healthcare, shape what people believe is true about healthcare.

However, a marketplace in which an estimated 80% of the providers or more have to compete with both arms and one leg tied behind their backs is NOT a COMPETITIVE MARKETPLACE.

Opening Remarks by Paul Ginsburg, PhD, President, Center for Studying Health System Change

Again this year, as he did at last years Hearings, Paul Ginsburg expressed his concern that Price Transparency could lead to a "race-to-the-top" in healthcare pricing, especially if smaller providers with lower reimbursements see how much higher the reimbursements are to the larger, more powerful providers.

If price disclosure occurred and nothing else changed, then it is entirely plausible that smaller providers would want to be paid the same as larger, more powerful providers, especially when the smaller provider delivers treatment that is consistently equal to or better than the quality of the larger provider. However, in normal competitive markets, more aggressively priced suppliers will attract customers by offering a better price/quality combination than their competitors. The converse is that higher priced suppliers, as they begin to lose customers, will be compelled to lower their prices. Isn't that what COMPETITION is all about? You cannot have Price Transparency without giving consumers both the authority AND the INCENTIVE to choose higher value providers.

So no matter how good the information is on the APCD website, unless the information is accompanied by a corresponding change in healthcare law that both permits and REWARDS consumers for shopping for healthcare value, the APCD will become just as irrelevant as myhealthcareoptions.

Opening Remarks by Dr. Ralph de la Torre at the Health Care Cost Hearings:

Following his opening remarks on the Response Panel for Relational Coordination in Healthcare, Ralph de la Torre, MD., President and CEO of Steward Health Care System, declared that "the days of rugged individualism are over. Healthcare in the future will only be delivered by large, highly integrated and highly coordinated health systems."

Now I have to admit, until I heard Dr. de la Torre's remarks, I actually had no idea that the days of rugged individualism were over, I assume forever. But, in light of Dr. de la Torre's proclamation, and in recognition of this transitional moment as we pass from an era of rugged individualism to a new era of globally integrated and globally coordinated healthcare, I would like to propose that we celebrate this moment with a good old fashioned shootout at the OK Coral. At a minimum there would be three participants in this shoot out. They would be Steward Health Care System, Partners HealthCare and my company, Laurel Hill Inn. This shootout will closely approximate the way in which a competitive market would function.

The value of the shootout would be its ability to move us all beyond the rhetoric and the theorizing. The shootout would lead us all to a far more substantive and definitive

(evidence-based) way forward in healthcare Reform. Consider that ACO's and Global Payments require us to abandon what have been guiding principals in American commerce going back to the late nineteenth century. These principles continue to guide all aspects of commerce outside of healthcare, even in international commerce.

This would be an opportunity for Steward Health Care System, under the gifted leadership of Dr. de la Torre to showcase for the world the advantages that a globally integrated and globally coordinated healthcare system such as Steward, bring to the average healthcare consumer.

Now, my company is a specialty provider. We offer intensive treatment only to women who struggle with serious eating disorders. Intensive treatment includes Acute Residential Treatment (24X7); Partial Hospital Program (M-F/ 6.5 hrs/day) and Intensive Outpatient Treatment (M-Th/3 hrs/night). While Steward does not offer these specific services, Dr. de la Torre's close friend, colleague and mentor, Jack Connors, Chairman of Partners HealthCare, does offer two of these services (ART & PHP) at his own globally integrated and globally coordinated healthcare system. The name of Mr. Connors' program is The Klarman Center and it is located on the grounds of McLean Hospital.

I would like to propose that Dr. de la Torre and Mr. Connors "collaborate" with one another in preparation for this shoot out. I'd be more than happy to give credit to Dr. de la Torre for any woman who chooses to be admitted to the Klarman Center (Partners HealthCare) instead of being admitted to my company's program, Laurel Hill Inn. I realize that the word "collaborate" could raise some antitrust concerns with the FTC. Therefore, I would propose that Christine White, Attorney, Federal Trade Commission, Northeast Regional Office, establish a "SAFETY ZONE" around the entire combined operations of Partners HealthCare and Steward Health Care System to be certain that all of Dr. de la Torre's and Mr. Connors' communications are "protected".

I realize further that the FTC customarily likes to get some number of attorneys involved in these situations to determine whether the "collaboration" should be allowed to occur at the 40% level, the 60% level or the 80% level but I'd prefer to let these two healthcare rock stars communicate without restriction of any kind so that the Legislature, the Governor, the MA AGO, the Division, the US DOJ and the FTC can experience first hand the full impact of what it means to be a globally integrated and globally coordinated healthcare provider, particularly in so far as how these attributes may enable the integrated/coordinated provider to outperform a provider who would be considered by most of Big Health Care to be totally disintegrated- that would be me.

I'd like to propose further that the de la Torre/Connors team and I supply independently to the MA AGO, guidelines which will instruct individual healthcare consumers as to how they might go about shopping and comparing among intensive treatment providers in order to intelligently evaluate the many program attributes that bear on the effectiveness of treatment.

Since Partners HealthCare only serves girls and women between the ages of thirteen and twenty-three, and since Laurel Hill Inn is only licensed to serve women eighteen years of age and older, this shootout will be limited to serving women between the ages of eighteen and twenty-three, a six year age span.

Any woman who has benefits from any insurance company that contracts with Partners HealthCare (including any direct contracts with Mass General Hospital, McLean Hospital and/or The Klarman Center itself) as well as any woman who has insurance benefits with any of the four Plans that currently contract with LHI (BCBSMA, Tufts Health Plan, Cigna, Aetna) will be told that she has the right to direct her benefit dollars to the provider of her choice, provided that she is willing to pay any difference between her benefit dollar amount and whatever the per diem price might be that each provider chooses to charge. Such a process will approximate the functioning of a competitive marketplace.

Further, I believe that once the MA AGO confirms that the Klarman Family committed $500,000/year in subsidies to Partners HealthCare for the first five years of operation of The Klarman Center, in order to entice Partners to establish an acute residential treatment program for adolescents and young women with eating disorders, the MA AGO will likely insist on awarding my company a handicap in the shoot out. However, my company will not accept such a handicap. It's also possible that the $500,000/year subsidy from the Klarman Family to Partners HealthCare may have continued beyond year five but I am uncertain of this.

My company does not accept donations. However, it is not donations that would have enabled my company to expand its operations. Had my company enjoyed the simple right to compete in the intensive treatment market without restriction, we most likely would have expanded our operations substantially, possibly to include services to low income clients. As a result of blocked access for Members with United HealthCare Plans alone, including its affiliates and subdivisions, we have lost conservatively, millions of dollars in revenue.

Since the Hearings had a strong focus on healthcare costs, I paid special attention to Dr. de la Torre's insightful comments about costs. He states, *"...we must understand the factors driving cost. The cost of health care has two fundamental components: the cost of a unit of care (i.e., an X-ray, a procedure, a hospitalization) and the total number of units of care consumed (utilization). These two combine to construe total medical expense (TME)."*

I noted that Dr. de la Torre mentioned the word "cost" 33 times in his opening remarks; he mentioned the word "efficiency" 10 times and he mentioned the word "value" twice. So I'm going to go out on a limb here and say that driving down healthcare cost (by any means necessary) is a top priority for both Dr. de la Torre and Steward Health Care System.

I think Dr. de la Torre's focus on "unit of cost" is exactly where the focus needs to be. However I was not certain that Dr. de la Torre's understanding of the role that unit cost would play in healthcare delivery was exactly the same as mine and so, I do have some questions. I'm hoping that Dr. de la Torre's "actual" unit of cost somehow relates to the word "Accountable" as in Accountable Care Organizations. But I wasn't clear exactly on how the two were related. Does the word Accountable mean that the ACO is "accountable" for the actual unit of cost? Who exactly is the ACO accountable to? Can we expect to see

this unit of cost appear in places like the APCD? Will the amount that a healthcare consumer pays in the future when she receives a unit of healthcare have any relationship to the unit of cost to which Dr. de la Torre refers or, will the relationship remain as it is today, i.e. purely fictional.

Dr. de la Torre commented further that, *"The unit cost component is comprised of supplies, fixed costs and labor costs. Hence, controlling an individual hospital's expenses can be achieved primarily by driving down supply, or labor costs. A hospital operating efficiently can decrease the unit cost mainly through layoffs or at a minimum, by cutting supply costs."*

I'm happy to see that Dr. de la Torre is using the word "layoffs" because that means he's been talking to Mitt Romney, Godfather of the healthcare access miracle in Massachusetts. Anyone who's been exchanging ideas with Mitt Romney about healthcare certainly has lots of credibility with me.

For the purposes of this discussion, I'd like to change Dr. de la Torre's cost terminology just slightly. Where he talks about "supplies, fixed costs and labor costs" I'd be inclined to use the words Direct Costs and Indirect Costs. Direct Costs are also often referred to as Variable Costs and Indirect Costs are often referred to as Overhead or Fixed Costs. Fixed Costs, for the most part, do not vary with the amount of procedures performed while Direct Costs, for the most part, do have a positive correlation with the number of procedures performed.

When I go in for my hip replacement, there would be both Direct and Indirect Costs associated with my procedure that might look something like the following.

DIRECT COSTS	**INDIRECT COSTS (a.k.a Overhead/ Fixed Costs)**
DIRECT LABOR	INDIRECT LABOR
SURGEON	ADMINISTRATIVE PERSONNEL
ANESTHESIOLOGIST	MARKETING & SALES
NURSES	BUILDING MAINTENANCE PERSONNEL
	EQUIPMENT MAINTENANCE PERSONNEL
	STRATEGIC PLANNING & DEVEL PERSON.
DIRECT MATERIAL	INDIRECT NON-LABOR
SUPPLIES	BUILDING MAINT /REPAIRS
BLOOD /PLASMA	EQUIPMENT MAINT/ REPAIRS
MEDICATION	NEW BUILDINGS, PLANT DEVEL, EXPANSION
SHEETS	NEW EQUIPMENT

As you can see, the Direct Costs are immediately related (directly related) to my procedure whereas Indirect Costs are only tangentially related or perhaps entirely unrelated to my procedure.

In a truly competitive marketplace the provider needs to be concerned with how costs are allocated across all of these categories of spending. Overspending in anyone category could drive up his costs sufficiently such that a competitor may offer a better cost-quality combination (i.e. value) which causes the more expensive provider to lose the business. So the provider needs to attract and compensate eminently qualified specialists that will perform my hip replacement but they must not be overcompensated thereby making the provider uncompetitive and potentially losing business.

As a consumer seeking this procedure in a competitive healthcare market (not to be confused with the market we have today), I would be responsible for a substantial portion of the cost of this procedure myself and what I must pay will vary directly with the total actual cost of this procedure, most of which is paid for by my insurance company or through a "catastrophic-insurance-only" plan sponsored by the US Government.

Therefore, as I proceed to evaluate different providers who might perform my procedure, I will be concerned not only with the reputations of the specialists who would perform my procedure, but I will be greatly concerned about the total costs associated with this procedure as well. In the end I will make a purchasing decision based on the combination of medical expertise and total cost that is associated with this procedure, very much as I would if I were making any other major purchasing decision that would impact the quality and security of my life.

As a prospective patient in a truly competitive healthcare market, I can assure you that there is no one on the planet who is more motivated to make an informed value-based selection among different healthcare providers than me. The vast majority of Americans are just as capable of making informed value-based choices, particularly if they start with recommendations that their PCP or other healthcare professional might have. My company meets people like this every week.

The good news is that all of the effort that was expended by all of the providers to come up with the specific combination of medical expertise and cost that was offered to me did not cost society or the government a single dime. Also, I was more than happy to perform my own due diligence in this matter and again, my effort was FREE.

In the current MA healthcare market as well as in the Accountable Care Organization/ Global Payment market of tomorrow, total cost of the procedure is NOT RELEVANT to me because I have neither the INCENTIVE nor the AUTHORITY to shop without restriction for optimum healthcare value.

INDIRECT COST (a.k.a. OVERHEAD):

In a traditional competitive marketplace, each product's value and profitability must stand on its own. Therefore, each product or service would be expected to carry not only its direct cost burden but it's fair share of relevant overhead cost burden as well.

Today's large healthcare delivery systems and tomorrow's ACO's need not be concerned about how costs are allocated across many procedures and treatments since procedure level spending is not visible to the consumer. Since the consumer has neither the visibility, nor the incentive, to scrutinize how procedures are priced out and make purchasing decisions accordingly, today's healthcare delivery systems and tomorrow's ACO's are essentially free to allocate their money across various expense categories however they see fit.

Since the allocation of costs to overhead (i.e. fixed costs or indirect costs) is entirely discretionary, and since the ACO need not worry about procedure level costs, it's decisions about overhead spending may not be guided by the best interests of the consumer or society as a whole. In fact, investments in overhead by the current healthcare system may represent reckless or even predatory choices such as the following examples show.

- In today's healthcare market and the ACO market of tomorrow, since the consumer has neither access to, nor the ability to use actual cost data to guide her purchasing decision, the ACO may choose to engage, without penalty, in a predatory expansion of its facilities and services into the suburbs where demand for needed services is already being met by local hospitals.

- The ACO may choose to fund the development of facilities that would be unaffordable if such development needed to be funded by the ACO's cash flow from operations in a competitive marketplace where all consumers were both authorized and incentivized to shop for optimum healthcare value.

- The ACO may choose to engage in exotic medical research that may help a tiny number of people while depriving basic and reasonable healthcare access to the masses. The ACO would do this because the achievements of such exotic research may put the ACO on the cover of the New England Journal of Medicine whereas basic healthcare access garners no such professional acclaim.

- The ACO may choose to construct an $8M museum to showcase medical innovation in its front lobby simply because it can allocate this cost to the overhead charge of every procedure performed by the ACO and such expenditures are not constrained by consumers who wish to shop for healthcare value. The ACO may claim that the museum is funded by private donations but there is really no way to prove whether funding for the museum is paid for by donations or is paid for by an extra burden added to the overhead charge carried by every procedure performed throughout the hospital system.

- The ACO spends precious healthcare dollars on consultants, lobbyists, politicians and various other forms of expert opinion in order to promote marketing messages whose primary purpose is to spin the healthcare system's policies so that they are perceived favorably by the public, the legislature and others.

This last category of industry consultants, who offer their expert opinion to support any proposal in any business plan for any institution that has the money to pay for it, represents a line item in which millions of dollars could be redirected back into value-based healthcare. In a truly competitive healthcare marketplace, large providers would have no choice but to focus on the quality and cost of the procedure being provided because that is where the success or failure of the company's future will be determined. All of the millions of dollars of spending on what is essentially "spin" would no longer have substantive value.

MY OBSERVATION ON COST STRUCTURE

In light of the important observations made by Dr. de la Torre regarding hospital cost structure and its ultimate influence on health care pricing, permit me to offer an observation of my own on this same topic.

There is a fundamental difference between Partners HealthCare and my company. It is the same fundamental difference that distinguishes Steward Health Care System from my company. That difference is called OVERHEAD. They have major overhead; LHI's overhead is minimal.

As a consequence of this difference in cost structure my company is able to invest a far greater percentage of each revenue dollar into frontline, face-to-face professional clinical resources (a.k.a. DIRECT LABOR) than is either Partners HealthCare or Steward Health Care System. Partners and Steward, by virtue of how they are structured, must dedicate a far larger portion of each of their revenue dollars to supporting their layers and layers of management as well as the millions of tons of glass and concrete, granite and steel that are associated with their respective operations.

As mentioned earlier, investments by these institutions in expanding their operations into other application areas, other geographies, research endeavors and/or technology acquisition would also appear in OVERHEAD cost and usually will have nothing to do with the quality or effectiveness, including cost effectiveness, of any specific treatment such as intensive treatment for eating disorders.

Opening Remarks by Gary L. Gottlieb, M.D., M.B.A., President and CEO, Partners HealthCare System

Essentially, what Dr. Gottlieb is saying is that PHC does wonderful and extraordinary things for all of humanity that no one else can do and he would be happy to keep the money pouring in and retain complete control over how to spend it.

Given the substantially healthcare driven economic crisis that we face in Massachusetts today, it would appear that the way in which money has been collected and allocated among a vast array of healthcare choices has not been carried out so as to serve the best interests of most people in Massachusetts.

Toward the end of his remarks Dr. Gottlieb stated, "The Division's report on price variation is only one step in assessing why hospitals are reimbursed differently from one another, and we welcome a more detailed examination of the issue as the Special Commission on Provider Price Reform begins its work. "

HOW IDEAS GET GENERATED, MARKETED and SOLD

Several years ago even before Health Care Reform was christened in Massachusetts, Big Health Care saw what was coming. It was clear to Big Health Care that there was no existing mechanism that could impose any kind of restraint or restriction on health care spending by the most powerful stakeholders and stakeholder partnerships. It didn't take a lot of logic to foresee that runaway prices were coming; the public would eventually challenge those runaway prices and demand that prices be controlled. One of the first things that the public would demand would be transparency, i.e. where is all the money going and why.

Transparency is not something that Big Health Care could accommodate while trying to defend massive disparities in prices paid to different hospitals. Big Health Care needed a strategy, some kind of way to dodge the transparency and accountability bullets that would eventually come. Big Health Care's response to demands for Transparency and Accountability were/are Accountable Care Organizations and Global Payments.

Observing the means by which these vehicles (ACO's /GP's) were rolled out has given me an appreciation for the money and power that are behind these strategies. The amount of money sloshing around right now between Big Health Care and State Government will make it difficult to implement strategies that represent the best interests of consumers.

As I reflect back on the several sessions of the last Special Commission on the Health Care Payment System that I attended, I recall that someone tried to slip into the Commission's basket of ideas what sounded like a disguised proposal for more robust competition in healthcare. The proposal was called "Consumer Skin in the Game". I was surprised that such a radical suggestion actually made it onto one of the overhead slides. "Skin in the Game" is what we all have when we go shopping for everything in our lives except healthcare.

Needless to say, the "Skin in the Game" idea died a discreet and quiet death under the watchful eyes of Sara Iselin, Co-chair of the Special Commission. I thought Ms. Iselin did an excellent job, however, of giving back to Big Health Care exactly the same recommendations she was handed prior to the Special Commission first convening- Accountable Care Organizations and Global Payments. It would seem that the entire

Special Commission process was supposed to look as much as possible like a full-fledged brain storming session (no ideas excluded) by all of the major financial stakeholders in healthcare. However, it would be difficult for any objective person to see this process as anything other than political theater. Sometime after her tour of duty with the Special Commission concluded, Ms. Iselin was appropriately rewarded for her work by being appointed to the position of President of the Blue Cross and Blue Shield of Massachusetts Foundation.

You will recall that a few years ago, the Boston Globe reported that the Chairman or Partners HealthCare called up his counterpart at Caritas Health Care, Cardinal Sean O'Malley, and told the Cardinal, "I'm sending over your next CEO right now. His name is Dr. Ralph de la Torre." This should not be happening between two companies that should be competitors. Partners HealthCare and Steward Health Care control just under 44% of the hospital beds in the Boston market (Globe 6/9/11). Could you imagine the Chairman of Boing Company calling up the Chairman of Northrop Grumman Corp and saying, "I'm sending over your next CEO right now."

The MA AGO has performed persuasive analyses and developed important conclusions based on those analyses. The analyses provide important insights into the reasons for the fiscal failure of Massachusetts healthcare. However, the most effective and cost effective ways to proceed with healthcare Reform have not yet been demonstrated.

If the MA AGO's analyses and recommendations were being presented to an audience that was guided by logic and reason and common sense, it's likely that healthcare Reform would begin to move in the right direction in Massachusetts. However, it is far more likely that the MA AGO's healthcare reform recommendations will encounter a wall of money and influence when they go to Beacon Hill. That does not bode well for future policy.

The MA AGO and the Division can learn a great deal by experimenting with competition and transparency on a small scale- a pilot project if you will. It can also learn a great deal about how consumers who are unrestricted in their choices go about making their healthcare procurement decisions. Both of these kinds of exploratory pilot programs would likely lead to the development of policy recommendations that are more irrefutable than recommendations that are largely extrapolated from data.

SUMMARY

I'm sure that the MA AGO and the Division both have their own interpretations of the messages that are currently being communicated by Big Health Care to the Legislature and to any other state entity that dares to challenge their power and authority. But permit me to offer my own interpretation of Big Health Care's message:

> *We're big Health Care. We are members of a medical aristocracy that holds the power of life and death in our hands. In fact we will decide who lives and who dies. For this reason, we will not allow our work to be subjected to the demeaning scrutiny of a competitive marketplace.*

We are pursuing the implementation of Accountable Care Organizations and Global Payments because it will enable our work to continue without the distraction of unnecessary investigations such as the one currently ongoing. Once ACO's and Global Payments are fully implemented it will render such examinations into the cost and quality of our work meaningless since any authority the State might still have to regulate our operations would be authority in name only. We alone will decide how our performance and our cost effectiveness will be judged.

The MA AGO, the Division, the US DOJ and the FTC are currently overseeing one of the biggest money and power grabs in American History.

I don't have an insider's understanding of exactly how the game plan for Healthcare Reform evolved to its current point. But here's what I think I know.

Since Healthcare Reform has been a top priority for this President, he decided it might be a good idea to party with Jack Connors and Dr. Ralph de la Torre. It would appear that Mr. Connors and Dr. de la Torre persuaded the President that what's really wrong with US Healthcare is that there's just too much competition and it's all too fragmented. The true path toward higher quality, lower cost healthcare, according to Jack Connors and Dr. de la Torre, is to destroy (consolidate) most community hospitals and let the remaining few be acquired by massive medical empires, the development of which will be strongly encouraged (required) by this Administration and we will call these medical empires Accountable Care Organizations.

As ACO's proceed to acquire the remaining community hospitals, I'd like to think they will agree to not raise prices on all of the services previously provided by the community hospital by any more than 20%, at least not in the first year after acquisition.

I'm guessing that the President would have come back to Washington and sat down immediately with the US DOJ and the FTC and explained the new healthcare game plan which is: force the aggregation and control of as much of America's healthcare delivery resources (hospitals, physician groups, etc.) under as few corporate entities as possible and we will have solved America's healthcare's cost and quality problems. Apparently the US DOJ and the FTC agreed that reducing competition in US healthcare and consolidating all healthcare delivery resources was a great idea.

Now, if ACO's were an untested theory I could understand why this Administration might want to "test the water" with the ACO concept. However, the theory of massive concentrations of healthcare wealth and political influence has already been tested in the Commonwealth of Massachusetts. That pilot project was and continues to be a joint venture between Partners HealthCare and Blue Cross and Blue Shield of Massachusetts.

I strongly encourage the MA AGO and the Division to slow down the Commonwealth's escalating rush to ACO's and pilot test the logical alternative- direct competition among all suppliers of procedures, treatments and services in a very specific, well delimited marketplace.

Respectfully submitted,

William H. McDonald
President
Laurel Hill Inn
bill@laurelhillinn.com
781 396-1116 (W)

cc: William Matlack, Chief of the Antitrust Division, Office of the Attorney General
Tom O'Brien, Chief of the Healthcare Division, Office of the Attorney General
Lois Johnson, Assistant Attorney General
Seena Carrington, Acting Commissioner, Division of Health Care Finance & Policy
Greg Sullivan, Inspector General
John Craven, Office of the Inspector General